

SILVER

Plan Year Deductible

\$500 *per Individual*
\$1,000 *per Family*

Out-of-Pocket Maximum

\$3,000 *per Individual*
\$6,000 *per Family*

Lifetime Maximum

\$2,000,000
per Person

		Co-Pay *	Deductible	Plan Cost Sharing
Professional Office Visits	<i>These charges are billed by the physician for time spent with the patient. Coverage includes Preventive Check-Ups & Physicals, Maternity: Pre & Post natal care. Office visits do not include charges for diagnostic, surgical or medical procedures performed by the physician. Medication Management limited to 4 visits per year.</i>			
Well Child Care (Up to 24 Months)		\$10	N/A	100%
Primary Care		\$20	N/A	100%
Specialist		\$40	N/A	100%
Outpatient Diagnostic Tests, Lab & X-Ray	<i>Includes diagnostic tests performed in a physician's office or a free standing non-hospital based facility only.</i>	\$20	N/A	100%
Vision	<i>Maximum annual benefit of \$60 after Copayment. Covered Person must submit claim for reimbursement.</i>	\$40	N/A	100%
Short Term Rehabilitation Services	<i>Physical, Chiropractic, Speech and Occupational Therapy: Up to 30 visits per condition, per Plan Year.</i>	\$40	N/A	100%
Emergency Services				
Hospital Emergency Room (Facility Charge Only)	<i>ER Copayment waived if admitted;</i>	\$150	N/A	100%
Urgent Care/Physician	<i>\$500 penalty for non-emergency use of a hospital emergency room.</i>	\$20	N/A	100%
Ambulance		\$40	N/A	100%
Allergy Treatment				
Testing and Injections		\$20	N/A	100%
Serum		\$100	N/A	100%
Inpatient Hospitalization				
Medical Services and Facility	<i>Organ Transplant Benefits are subject to specific procedures and limitations as indicated in the Organ Transplant Benefits section of the SPD.</i>	N/A	APPLIES	80%
Anesthesiologist and Surgeon Fees		N/A	APPLIES	80%
Outpatient Services				
Medical Services	<i>Includes outpatient services or procedures at a freestanding surgery center or hospital (when approved), miscellaneous medical services and supplies. Including, but not limited to Surgical, Diagnostic and Therapeutic Procedures. Surgical/invasive procedures done in a physician's office also included.</i>	N/A	APPLIES	80%
Facility Charges		N/A	APPLIES	80%
Home Health Care & Skilled Nursing Facility	<i>Up to 60 days or visits in a Plan Year.</i>	N/A	APPLIES	80%
Hospice Care		N/A	APPLIES	80%
Mental Health & Substance Abuse				
Inpatient Hospitalization	<i>Excludes counseling for behavioral disorders.</i>	N/A	APPLIES	80%
Outpatient Office Visits		\$40	N/A	100%
Durable Medical Equipment	<i>Maximum annual benefit of \$5,000 per person, per Plan Year.</i>	N/A	APPLIES	80%

* Copayments *never* apply to the Plan Year Deductible or Out-of-Pocket Maximum.

Pre-Certification Penalty: Certain procedures or medical care require pre-certification in order to qualify for full benefits. Failure to pre-certify will result in a \$250 penalty per service, procedure or confinement. Please refer to the Pre-Certification section in your SPD for details.

Please Note: This schedule applies as indicated in the Summary Plan Description. This schedule must be read in conjunction with the entire Summary Plan Description and has no full meaning by itself.